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Comprehensive Care Model for Sex Trafficking Survivors

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Abstract

Purpose: The purpose of this study was to identify aftercare services for domestic minor of sex trafficking (DMST) survivors provided by U.S. residential treatment centers.
Design: A qualitative research study was conducted with aftercare program personnel from five U.S. residential treatment centers for DMST survivors.
Methods: Interviews were conducted with staff from five different residential treatment centers providing services exclusively to domestic minor sex trafficking survivors.
Findings: Participants described the range of services offered to address survivors' posttrafficking needs. Participants' responses assisted in expanding an existing care model to include education re-entry, family reunification, family reconciliation, and emergency substance use services.
Conclusions: This study led to the refinement of an aftercare service delivery model and laid the foundation to develop best practice guidelines for providing aftercare services to DMST survivors.
Clinical Relevance: Sex trafficking is a global health problem affecting our youth today. Nurses have a vital role in combatting sex trafficking by raising awareness about the problem and restoring the lives of sex trafficking victims by implementing innovative care programs.

Sex trafficking is defined as "A commercial sex act induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age" (Trafficking Victims Protection Act, 2000, p. 8). Epidemiologically, sex trafficking is extremely difficult to track, and prevalence remains unknown, with conservative estimates between 50,000 and 100,000 trafficked victims a year in the United States. Globally, 1.2 million children are estimated to be trafficked annually, and the industry of human trafficking generates approximately US$32 billion annually (Davidson, 2013). The United States is known as a source, transit, and destination country for men, women, and children who are U.S. citizens and foreign nationals (U.S. Department of State, 2016). Trafficking victims are recruited from around the world to the United States. In 2015, the top three countries of origin for trafficking victims in the United States were from the United States, Mexico, and the Philippines. The most vulnerable populations at risk for trafficking are children in the welfare system and juvenile justice systems, runaway and homeless youth, persons with disabilities, and lesbian, gay, bisexual, transgender, and intersex (LBGTI) individuals (U.S. Department of State, 2016). Estimates from Clawson, Layne, and Small (2006) indicate that approximately 400,000 females are at risk for sex trafficking in the United States, with traffickers preying on youth as young as 12 years old (National Human Trafficking Resource Center, 2016). In 2014, the National Center for Missing and Exploited Children (2016) reported that one in six runaways were likely sex trafficked, an increase from one in seven runaways in 2013. Traffickers target these vulnerable populations and use tactics such as force, coercion, befriending, and seduction, the latter being the most commonly used tactic to recruit victims (Lloyd, 2011).

Domestic minor of sex trafficking (DMST) survivors endure an array of health consequences after having exited a trafficking situation. The psychological and behavioral

effects include low self-esteem, loss of self-confidence, anxiety, panic attacks, depression, hopelessness, post-traumatic stress disorder (PTSD), substance abuse disorder, suicidal ideations, attachment disorders, mistrust of adults, antisocial behaviors, difficulty relating to others, developmental delays, language and cognitive difficulties, deficits in verbal and memory skills, and poor academic performance (End Child Prostitution, Child Pornography and the Trafficking of Children for Sexual Purposes, 2006; Rafferty, 2008; Shigekane, 2007; Twill, Green, & Traylor, 2010; Williamson, 2006; Williamson, Dutch, & Clawson, 2008; Zimmerman et al., 2008). The physical effects include complications from high-risk pregnancies and unsafe abortions; headaches; fatigue; dizziness; pain (e.g., back, stomach, pelvic); sexually transmitted diseases, including HIV/AIDS; and gynecological infections (Rafferty, 2008; Williamson, 2006; Zimmerman et al., 2008). Given the magnitude of health effects on trafficking victims, a holistic approach to address the physical, psychological, and emotional needs of DMST survivors is necessary (Mayhew & Mossman, 2007). Healthcare professionals working in an emergency room, primary care clinic, or school have a pivotal role in identifying and assisting DMST victims in exiting a trafficking situation and connecting them to aftercare services (Goldblatt-Grace, Starck, Potenza, Kenney, & Sheetz, 2012). The purpose of this study was to identify aftercare services for DMST survivors provided by U.S. residential treatment centers. The American Association of Children's Residential Centers (1999, p. 1) defines residential treatment centers as "An organization whose primary purpose is the provision of individually planned programs of mental health treatment, other than acute inpatient care, in conjunction with residential care for seriously emotionally disturbed children and youth, ages 17 and younger."

Previous research has shown that an array of aftercare services is recommended for sex trafficking victims. Willis and Levy (2002) emphasized the need for sustainable medical and psychological support, education, and vocational training after exiting a trafficking situation. Spear (2004) identified an expansive range of resources needed for providing services to trafficking survivors including medical care, education, substance detoxification, counseling, job skills, and residence. Williamson (2006) emphasized the need for case management, safe and long-term housing, education, vocational training, medication management, and trauma treatment, all under the care of qualified, educated, and empathetic staff. Busch-Armendariz, Nsonwu, and Heffron (2011) identified five long-term needs of trafficked women, including safety, medical health, emotional and psychological health, financial stability, and social and familial equilibrium. Legal advocacy to expunge misappropriated convictions (e.g., juvenile prostitution) from sex trafficking victims' records and to advise and represent victims in prosecuting their traffickers is a necessary aftercare service. Antitrafficking laws are shifting from a place of victim blaming where victims are penalized for criminal acts their traffickers forced them to engage in to a place where victims receive aftercare services to facilitate recovery, prevent retraumatization, and eliminate barriers for obtaining an education, housing, and future employment (U.S. Department of State, 2016). Thirty-four states have passed "safe harbor" laws that provide trafficking victims with immunity from prostitution offenses and increase participation in victim assistance programs (U.S. Department of State, 2016). Foreign trafficking victims are eligible for victim assistance services and benefits similar to refugees residing in the United States (U.S. Department of State, 2016). In the Trafficking in Persons report, an annual publication produced by the Office to Monitor and Combat Trafficking in Persons, provided a list of recommendations to reinstate psychological well-being of trafficking survivors, included ensuring survivors' safety, soliciting the support of health providers' knowledge in trauma-centered care, providing collaborative therapies, creating an environment that fosters empowerment, assessing for medical conditions and mental illness, providing unconditional support, supporting social and family reunification, rebuilding identity, and re-establishing skill sets and self-esteem (U.S. Department of State, 2012). Forms of psychosocial care are advised to begin as soon as possible after an initial assessment and development of an individualized treatment plan for trafficking victims (Clayton, Krugman, & Simon, 2013).

Trauma-focused cognitive behavioral therapy (TF-CBT), dialectical trauma-focused cognitive behavioral therapy (DTF-CBT), and eye movement desensitization and reprocessing are all trauma-based therapeutic approaches supported by evidence in treating individuals with PTSD or a history of child sexual abuse (Kotrla, 2010; Mannarino, Cohen, Deblinger, Runyon, & Steer, 2012). Substance abuse treatment programs may also be a necessary service for trafficking victims. Victims may either be forced or coerced into using substances while trafficked or they may engage in substance use as a negative coping mechanism posttrafficking, although it is important to note that not all victims are exposed to or develop a substance abuse disorder as a result of being trafficked (Lederer & Wetzel, 2014). Varma, Gillespie, McCracken, and Greenbaum (2015) found that 70% of commercial sexual exploitation of children (CSEC) youth used drugs or alcohol, and 50% of CSEC youth were found to use multiple drugs. Additionally, education has been found to be a significant factor in whether a trafficking victim builds safe, stable relationships to

avoid vulnerability to re-exploitation after services are provided (Van der Keur & Touch, 2013).

In 2011, Macy and Johns published a framework for a continuum of aftercare services to address international sex trafficking survivors. Macy and Johns identified seven core services to address the needs of sex trafficking survivors based on findings from their comprehensive literature review. These core services included basic necessities (e.g., food, water); secure, safe shelter and housing; physical health care; mental health care; legal and immigration advocacy; substance abuse services; and job and life skills training (Macy & Johns, 2011). They categorized these core services into three domains, including immediate, ongoing, and long-term needs (Macy & Johns, 2011). Macy and Johns' framework was used in this qualitative descriptive research study to explore the aftercare services delivered at five residential treatment centers in the United States for DMST survivors. The University of Illinois at Chicago Institutional Review Board approved this research.

Methods

A comprehensive, Web-based search was conducted in 2011 identifying 14 U.S. residential treatment centers that met the inclusion criteria for this study, which were: (a) provided services exclusively to DMST survivors; (b) actively housed DMST survivors; and (c) provided services to males, females, and transgender DMST survivors 11 years of age or older. An additional 10 U.S. residential treatment centers were brought to the researcher's attention by a participant, a "gatekeeper" who contributed to the recruitment of additional participants for this study (Illingworth, 2001). Altogether, 10 out of 24 U.S. residential treatment centers met the inclusion criteria. Five service providers from these 10 U.S. residential treatment centers agreed to participate. Those who declined to participate were either too busy or did not respond to recruitment materials. The following inclusion criteria applied to participants: (a) held the job title of founder, program director and/or program manager of a U.S. residential treatment center; (b) was 21 years of age or older; and (c) spoke English.

In-depth telephone interviews were conducted with each participant following a 39-question semistructured interview guide. Participants were asked about the demographics of the DMST survivors served at their U.S. residential treatment center, the origin of referrals, general information about the U.S. residential treatment center (e.g., mission, vision, philosophy, organizational structure, etc.), information about employees and staff development (e.g., orientation, turnover, counseling services, satisfaction, etc.), the immediate, ongoing, and long-term needs of DMST survivors, and level of engagement with DMST survivors after leaving their U.S. residential treatment center. Verbal consent was obtained prior to the start of the interviews. All interviews were digitally recorded and lasted 60 to 120 min. After the completion of the interview, an online donation of $50 was made to the organization for their participation.

Digitally recorded interviews were then transcribed and accuracy of transcription was assured by listening and comparing the transcripts to the audio recordings. Creswell's (2009) six steps to qualitative data analysis were used to (a) organize and prepare data for analysis; (b) read through all the data; (c) code the data; (d) generate themes/categories for analysis; (e) provide representation of description/themes in the qualitative narrative; and (f) interpret the data. Glaser and Strauss's (1967) approach was selected as the preferred method to code data and began before the completion of data collection (Ulin, Robinson, & Tolley, 2005). Development of the original code list began after the first interview, resulting in 28 codes. Thereafter, the code list underwent six revisions with input from two independent team members, resulting in a final list of 27 codes. The coded transcripts were then uploaded to Atlas.ti (Atlas.ti Scientific Software Development GmbH, Berlin, Germany) to facilitate organization of the data. Across-case analysis was also conducted to identify the frequency of core services across U.S. residential treatment centers (Ayres, Kavanaugh, & Knafl, 2003).

Results

Immediate Needs

In comparison to Macy and Johns' (2011) framework, all participants reported immediate needs of crisis safety services, crisis shelter services, and emergency medical care; three participants reported basic necessities as an immediate need. Crisis safety services was viewed as imperative to the rescue and recovery of DMST survivors as exemplified in the following statement: "I think when they walk in the door their immediate need is to understand that they are protected and safe. So establishing a sense of safety and protection is important for these girls." In regards to crisis shelter services for incoming DMST survivors, participants believed that the provision of crisis shelter services was critical. One respondent stated,

> Well, ensure that they aren't an immediate victim of sexual assault and then offer them a shower. Or laundry services, food, and honestly a bed most of the time because even if they're just dropping in most of them have not slept, so just getting someplace where they can sleep in quiet for a little bit is a blessing.

Participants also viewed emergency medical care as an immediate need of a DMST survivor and critical to their recovery. One respondent reported, "Health care is the first thing that is addressed." The provision of basic necessities was also viewed as an immediate need. One respondent stated, "We try to make sure that all immediate needs, you know, food, clothing if they need it, shower, if they want it, and then rest is the first options for them."

In addition to the previously mentioned immediate needs, all participants reported initial case management in the form of a biopsychosocial assessment and development of a person-centered care plan based on the survivors' needs. One respondent stated, "Well, within 72 hours there's a needs and service plan that's done."

Based on the five interviews, three additional categories were considered immediate needs for DMST survivors, including emergency substance abuse services ($n = 5$), emergency mental health care ($n = 4$), and family reunification ($n = 3$). Participants viewed emergency substance abuse services as an immediate need for DMST survivors as exemplified in the following statement:

> If a child comes in and says that I've used cocaine, I've used marijuana or what have you, we have a drug and alcohol assessment done, then from that assessment we determine how deep the problem is. If the child needs to be in inpatient therapy for substance abuse then that's something that they need to go through first before they come back to our program.

Emergency mental health care was also viewed as an immediate need for DMST survivors. One respondent stated,

> We set up appointments with the psychologist, you know, then the psychologist determines. . . . You know, and we set-up an appointment with the doctor. The psychologist makes recommendations whether or not they think the child needs to be on medication. If the child needs to be on medication then we set up an appointment with the psychiatrist and, you know, so you're talking about a week or two trying to get all that coordinated.

Family reunification upon a DMST survivor's entry into the residential treatment center was viewed as an immediate need. One respondent stated,

> We know in congregate care that family involvement is the number one predictor of resiliency and so if they don't have any family I will shake that tree and find an aunt in New York that's willing to just talk to her once a week.

Participants commented on the importance of completing a comprehensive assessment to determine if DMST survivors had positive, healthy relationships with family members before reuniting them.

Ongoing Needs

All participants provided physical health care, mental health care, and safety services (e.g., home security systems); four participants reported the provision of legal advocacy. The ongoing provision of physical health care, mental health care, and safety services was viewed as essential to the recovery of DMST survivors. In regards to physical health care, one respondent said, "So that's kind of it on a sort of week-to-week basis besides, you know, every now and then doctor's appointments and there's medication appointments." The provision of mental health care as an ongoing need is reflected in this respondent's statement: "You know, I run two of the [therapy] groups a week. Another therapist runs groups another day of the week and the caregivers, the direct care staff facilitate two of the other groups." Safety services were provided through camera or door security systems. One respondent stated,

> Yes [referring to having cameras], we know who's on the outside, inside, all other kind of sides. That's their security and our security. Their safety and ours too. That keeps down accusations [referring to inappropriate relationships with staff or stealing] and all kinds of stuff.

While all participants did not report legal advocacy, it nevertheless was deemed a critical ongoing need to bring justice against victims' traffickers. One respondent stated, "She had an attorney that was appointed, you know by the feds or whoever the attorney was appointed by and we collaborated with that attorney to be able to put that particular perpetrator behind bars." All participants did provide a continuum of case management to meet survivors' ongoing needs. One respondent stated,

> And in that service plan there are various goals and various service plans that they have to go by before they can be discharged. . . . So we look at every individual, individualized treatment planning and see, you know, what each individual needs and take it from there.

Participants identified no new categories addressing survivors' ongoing needs.

Long-Term Needs

All participants provided life skills training and long-term housing at their residential treatment centers, and three participants provided job skills training. Life skills training included building healthy relationships with peers, grocery shopping, navigating public transportation, cooking, and building a support network among healthcare providers. Two participants used an independent living curriculum at their residential treatment center. The independent living curriculum covered basic life skills, including budgeting money, cooking, cleaning, shopping, and navigating public transportation. Long-term housing was deemed important as indicated by one respondent who said, "We've gone through periods where we've housed individuals for a couple of months at a time . . . always trying to get them into a more secure, stable permanent housing." Job skills training included creating resumes, looking for employment, role-playing for job interviews, and participating in a vocational training program. One respondent stated,

> Here's how you look for a job and here's how you would look for a job in your area and here's the jobs that are locally available that see, okay, we can pull their applications online, let's fill it out. . . . Now go in and you want to talk to the manager or assistant manager and here's the conversation you want to have. We role play it. . . . A job interview, let's role play that.

All participants provided ongoing case management to meet survivors' long-term needs. Case management included assisting DMST survivors with finding jobs, locating housing, or applying to colleges.

All participants identified two additional categories regarding the long-term needs of DMST survivors, including family reconciliation and education. Family reconciliation included supervised or unsupervised visitations, family counseling, and re-establishment of family connections (if appropriate). Education focused on survivors' involvement in a GED program or alternative high school, encouragement to enroll in higher education, and the provision of information and assistance to apply for available college scholarships.

Discussion

Framework Expansion

The results from this study supports an expansion to Macy and Johns' (2011) framework addressing the aftercare service needs of sex trafficking survivors. Services aligned with Macy and Johns' framework to address DMST survivors' immediate needs included crisis safety services, crisis shelter services, emergency medical care, basic necessities, and initial case management. Additional services identified to address DMST survivors' immediate needs included emergency substance abuse services, emergency mental health services, and family reunification. Emergency substance abuse services and emergency mental health care were provided by four of five participating residential treatment centers to meet survivors' immediate needs. The development of a substance abuse disorder after entry into trafficking occurs due to traffickers using substances to coerce victims and/or victims using substances as a negative coping mechanism to deal with the emotional pain of sex trafficking (Hardy, Compton, & McPhatter, 2013; Heilemann & Santhiveeran, 2011). It is important to note that not all trafficking victims are exposed to substances while being trafficked, nor do all trafficking victims develop a substance abuse disorder during or after being trafficked, but substance abuse services should be available if needed. Emergency mental healthcare services focused on delivering trauma-informed care (Muraya & Fry, 2015). Three of five residential treatment centers viewed family reunification as a key service contributing to the recovery of DMST survivors. The reunion of trafficking victims with their respective family presents numerous challenges, including the inability to locate a DMST survivor's family, survivors' resentment towards their family due to a lack of understanding of their trafficking experience, the presence of trauma-related symptoms (i.e., anger, irritability, sadness), family's lack of knowledge on how to deal with these symptoms, financial strain on a victim's family to cover healthcare related costs, and stigmatization of being trafficked (Brunovskis & Surtees, 2015). These are core services providers should consider as they develop person-centered and survivor informed care plans to address survivors' immediate needs.

Aftercare services aligned with Macy and Johns' (2011) framework to address DMST survivors' ongoing needs included physical health care, mental health care, safety services, case management, and legal advocacy. No additional services were identified to address DMST survivors' ongoing needs. Instead, participants stressed substance abuse services as more of an immediate need rather than an ongoing need, and transitional housing as a long-term need rather than an ongoing need.

Aftercare services aligned with Macy and Johns' (2011) framework to address DMST survivors' long-term needs included life skills training, job skills training, long-term housing, and case management. Additional services identified to address DMST survivors' long-term needs included education and family reconciliation. More research is needed on DMST survivors' re-entry

into school and home. It is important to note that determination of retransitioning back into their respective schools and homes is based on the presence of a safe environment and healthy relationships within the home. Job skills training was mentioned less than education, which could be due to the age of survivors, treated at these residential treatment centers.

Across the Macy and Johns (2011) continuum, some services (i.e., language services, crisis legal advocacy, immigration advocacy, language services, and language skills) were not identified as aftercare services for sex trafficking survivors. Since this was a national study and Macy and Johns' framework was an international representation of aftercare services for sex trafficking survivors, this finding could be related to the limited number of international sex trafficking survivors receiving services at these particular residential treatment centers.

Aftercare services to address DMST survivors' immediate needs are crisis safety services, crisis shelter services, basic necessities, emergency physical health care, emergency mental health care, emergency substance abuse services (if needed), family reunification (if appropriate), and case management. Aftercare services to address DMST survivors' ongoing needs are physical health care, mental health care, safety services, legal advocacy, and case management. Aftercare services to address DMST survivors' long-term needs are more focused on economic empowerment efforts, including life skills training, job skills training, long-term housing, family reconciliation, education, and case management. Other additions to the framework include accounting for relapse that is commonly experienced by DMST survivors along their path to recovery (Clawson & Grace, 2007).

Implications

There is a range of implications for nursing practice, policy, and future research that can be drawn from this study. In the climate of a tighter economy and insufficient allocation of funds to support aftercare services for DMST survivors, nurses can assist in coordinating care for DMST survivors across community agencies. Moreover, nurses maintain reputable positions across society and are pivotal to advocating for the needs of DMST victims. In particular, nurses can advocate for the passage of new legislation to identify youth as trafficking victims in need of aftercare services. Also, nurses can be influential in shifting individuals' perceptions on the treatment of DMST victims and bringing awareness to the needs of DMST survivors. Based on new findings from this study, further nursing research on the development of a framework for aftercare services to address sex trafficking survivors' needs and further evaluation of the effectiveness of these aftercare service programs for sex trafficking survivors is needed. Another area of further research is to evaluate the effectiveness of this model, residential treatment centers, in comparison to other care delivery models to meet the needs of DMST survivors. By studying the effectiveness of care delivery models, researchers will be able to better identify best practices for providing services to sex trafficking survivors. Lastly, the development of data collection systems is needed to better understand the demographics of DMST survivors seeking treatment; access to these data could result in nurses tailoring interventions to meet the population health needs of DMST survivors.

Limitations

This study was an initial step in understanding aftercare services provided at residential treatment centers for DMST survivors in the United States. Even though the sample size may appear small, it was adequate for this qualitative study given that 50% of the target population participated in this study. Limitations of this study included the inability to observe the natural settings of the residential treatment centers and inability to access data related to DMST survivors' outcomes from these residential treatment centers. Triangulation would have contributed to ensuring quality data; outcome data would have added to the richness of the data reflecting on the complexity of providing rehabilitative services to DMST survivors and evaluating the quality of services provided.

Conclusions

This study provided a deeper understanding of the range of services offered across five U.S. residential treatment centers and categorized these services accordingly based on the immediate, ongoing, and long-term needs of DMST survivors, as identified by Macy and Johns (2011). The major scientific advancement of this study was the refinement and expansion of Macy and Johns' framework. Overall, our understanding of aftercare services for DMST survivors continues to evolve. In the end, it will take a collective and coordinated effort among practitioners, researchers, politicians, law enforcement, court officials, and agency providers to expand our knowledge on aftercare services for DMST survivors in order to impact the care we provide to this vulnerable population.

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Clinical Resources

- Polaris Project: https://polarisproject.org/
- United Nations Office on Drugs and Crime: https://www.unodc.org/unodc/en/human-trafficking/
- U.S. Department of State. Office to Monitor and Combat Trafficking in Persons: http://www.state.gov/j/tip/
- U.S. Homeland Security: https://www.dhs.gov/blue-campaign/resources-available-victims

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